CHILDHOOD LANGUAGE CENTER, INC.

Authorization for Release of Information

Date_____

I _____do hereby grant permission to **THE CHILDHOOD LANGUAGE CENTER, INC.** to **release information** to assist in the evaluation, diagnosis, treatment, and/or education of _____to the following: doctors, school, insurance company.

Name	Address	Zip
Name	Address	Zip
Name	Address	Zip

PERMISSION IS GRANTED TO **THE CHILDHOOD LANGUAGE CENTER, INC.**

1 ( ) To release information to my child's doctor, insurance company or third-party payor (including physician, if required by insurance company) for the purpose of processing my claim for benefits.

2 ( ) I wish to receive a copy of the report.

PERMISSION IS GRANTED TO THE **CHILDHOOD LANGUAGE CENTER, INC.**

3 ( ) To receive clinical information to assist in the evaluation, diagnosis, treatment, and /or education of _____from the provider below.

Name	Address	Zip
Name	Address	Zip
Name	Address	Zip

Signature _____
Parent/Legal Guardian Relationship

Signature_____
Parent/Legal Guardian Relationship

Address_____

Telephone_____Work_____